

MEDICAL HISTORY

Name _____ Date _____

What concerns you about your eyes? _____

Have you ever had eye surgery? ___ Yes ___ No

If yes, please describe: _____

Drug allergies: _____

Medications: _____

Do you or any of your blood relatives have any of the following:
(Mark "S" for Self, "R" for Relative.)

___ heart disease ___ blindness ___ macular degeneration ___ stroke

___ diabetes ___ retinal detachment ___ cancer ___ thyroid disease

___ high blood pressure ___ cataracts

___ other (please list): _____

Please list all surgical procedures you have had in the past: _____

Do you have an optometrist? ___ Yes ___ No If yes, please list: _____

Do you wear glasses or contact lenses? ___ Yes ___ No If so, for how long? ___

Do you smoke? ___ Yes ___ No Do you use alcohol? ___ Yes ___ No

Are you pregnant? ___ Yes ___ No

Signature of Patient or Guardian Date